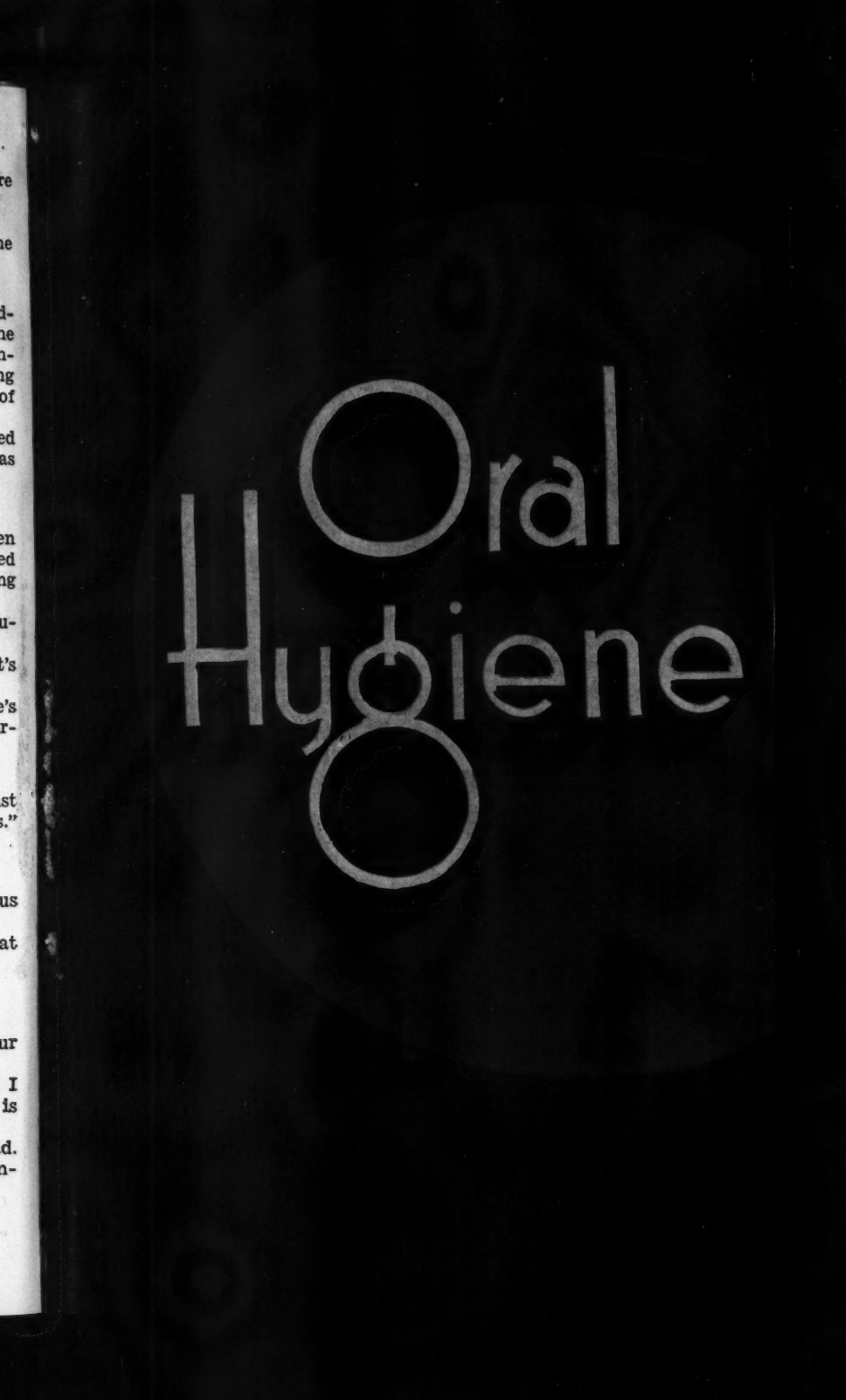
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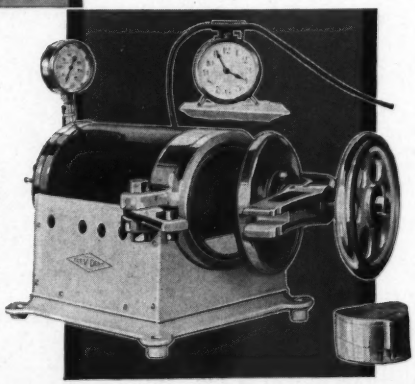

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So Far We've

FAILED

by DON C. LYONS, D.D.S., M.S., Ph.D.

THE DENTISTS IN this country need better training in the basic principles of public relationships and the science of teaching, not a special group, their patients, but the public at large. Believing that such is the case, let us examine the basis for this necessity. The dentist today treats only a small minority of the people, for it has been estimated by competent authorities that three out of four persons in the United States seldom brush their teeth, and consult a dentist for service only when driven to it by the necessity of having a tooth removed. Likewise a recent survey[1] shows that 23,000,000 school children are in serious need of dental care.

The wide-awake dentist apparently recognizes the need for change or reform in our present system of dental health education, because there has been a continual agitation for a better means or new methods of instilling the principles of dental health into the minds of the majority of the people in such a way as to make these concepts more effective. There are those who sincerely believe that this can be accomplished only by publicity of a blatant, clamorous type in newspapers and by radio, or essentially by a program which is nothing more than group sponsored advertising of the worst type. Another group is so conservative that they still consider health service as something too precious or too mysterious to permit public enlightenment. Then there is that group which consider all efforts for public health betterment as motivated by selfish interests, desire for self-advertisement, and by some lack of professional ethics. This latter group is entirely too large, as can be verified by any public health worker, but fortunately in the end they menace no one's interests but their own.

These groups seem to be accomplishing little of a lasting and substantial nature toward an adequate solution of the problem; a problem which must be solved by the dentists themselves, and soon, as is indicated by the present trend of social legislation. It is one which must be examined and solved by the trained scientific dental mind, or it will be brought to some sort of a conclu-

[1]Public Health Bulletin No. 226, Dental Survey of School Children, Ages 6-14 Years Made in 1933-34 in 26 States, U.S. Treasury Department, Public Health Service, Washington, D. C.

sion to the disadvantage of the dentist by others interested only from a political angle.

Analyze Past Efforts

Before considering our problem of health education from any angle, it might be well to check over the accomplishments or lack of accomplishments up to the present and try to analyze the apparent results. In other words, what are the net results of our previous efforts to disseminate dental health education?

Most of these efforts date back to 1914 and the years following when the nation was shocked at the tremendous physical deterioration discovered in the majority of those who volunteered or were drafted for the World War service. Since those formative years a more or less continuous program has been waged with some success and much failure. There is no question that it has succeeded in making the general public more conscious of dental beauty; at least the manufacturers of dental cosmetics or dentifrices have multiplied and prospered. But has the average dental health improved? Dental literature today is replete with reports which apparently answer the question for us.

Let us examine a few of these. Bruening[2] in the January issue of the *Journal of the American Dental Association* reported upon the disqualifying dental defects of applicants for entrance to the United States Navy during the past few years. Theoretically, if our previous efforts in dental health education of school children have been in some measure successful, these applicants should be nearly perfect from the dental point of view, for they are the young men who should have received the greatest benefit from our dental health education efforts. However, Bruening states that during 1934, 88,718 applicants were examined by United States Navy officials; of these 66,417 or 75 per cent were rejected; 17,590 or 26 per cent were rejected because of dental disease and oral conditions. In 1933 there were 43,948 young men examined and 30,900 rejected, of which 24 per cent were turned down on the basis of dental disease alone. This indicates, according to Navy regulations, that these young men did not have twenty vital teeth or had less than four opposed incisors, that their teeth in general were not serviceable, or other dental disease was present in excess of that permitted.

This group of young men grew up, went to school, and were at least exposed to much of the present effort in the field of dental health education. The end results in their particular cases are not favorable. There is of course one factor to be considered and that is the possible time effect of the depression; however dental health should not be based upon the number of teeth in which restorations have been placed, but on the percentage of whole

[2]Bruening, E. H.: Disqualifying Dental Defects, J.A.D.A. 24:150 (January) 1937.

ACCEPTED
REJECTED FOR DENTAL DISEASES
REJECTED FOR OTHER CAUSES
ACCEPTED
REJECTED FOR DENTAL DISEASES
REJECTED FOR OTHER CAUSES

sound teeth and gum soundness, or resistance to dental disease.

In 1934 the Committee on Public Health Education of the Saint Louis Dental Society decided to make a survey of the actual dental health of children in that city in order to determine what type of program should be instituted to improve conditions and estimate its necessity. The result of the work of this group is one of the most complete surveys of our problem to date, but it tells a sad story. This group found that the average need for dental attention was more than 95 per cent. Only in the kindergarten grades less than 90 per cent of the children required dental services. In the vocational and ungraded rooms 100 per cent of the children were dental cripples or in urgent need of adequate dentistry. In a total of 78,270 children examined, 67,744 children needed attention for gum disease or needed prophylaxis. There was an average of 3.15 cavities per child, and three times as many cavities were found as teeth with restorations. Fifty-one and four-tenths per cent of the children had malocclusion in some degree.

This Committee summarizes their report by stating that "For education we must look to the schools, and for dental health, we must look to the dental profession." That is a challenge to the dentists which must be met. During the years 1933-34 the United States Public Health Service assisted by approximately eight thousand dentists made a survey in twenty-six states of dental health conditions of the children from the ages of 4 to 14. A total of 1,356,435 white children and 81,883 colored children, divided equally as to sex, were examined. Study of the results shows that only in a few instances did the percentage of need for dental treatment fall below 80 per cent, the average being nearer 90 per cent, while the average amount of previous dental treatment found was in the neighborhood of 40 per cent.

These various findings indicate one thing; that, despite our efforts, the general public consisting of parents, young adults, and children have either received little benefit or they have assimilated none of the dental health knowledge available to them. These results indicate that although the dentist may have given unstintingly of his time and effort to improve dental health averages, he has not been able to reach the great mass of the public who still know little about the value of oral health. The direct result of this failure is that most of this group still consider dental service an unattainable luxury, despite their average ability to pay for needed attention. Usually it becomes unattainable because they neglect dental service to the point at which it becomes necessary for the dentist to do a considerable amount of restorative work.

This, briefly, is the situation which confronts those interested in dental health education from

an ethical point of view, at least ethical as based upon the present conception of the term. One can say definitely in looking over the results so far accomplished that the tooth brush drill and pamphlet broadcast type of dental health education are failures. The general public either thinks so or the dental profession is sound asleep politically for, as is shown in the United States Public Health Bulletin Number 227 entitled, "A Survey of Dental Activities of State Departments and Institutions of the United States," the average state appropriation for dental health activities is less than $5,000 a year. This figure includes salaries of dentists, secretarial expense, office expenses, printing and distribution of educational material, travelling expenses, and so on. This Bulletin shows that such a state as New York only spends $2,000 for dental health education activities; Illinois spends about $8,500; Connecticut, $2,700; and other states similar amounts; while California spends nothing. This report is well worth reading by those who consider that the public is really interested in dentistry as a health service. The reader receives a harsh awakening.

It, therefore, seems to me that satisfactory progress will not be accomplished until the dentist himself attains some understanding of the basic principles of the science of group education and the psychology of human responses. There are only four agencies by which education of any type can be spread; namely, by the written word, sight, speech, and association. There is a great waste of effort in employing these agencies unless the user realizes and appreciates that only 4 per cent of a person's time is devoted to becoming educated. Only a small part of the 4 per cent can be devoted to health education.

Likewise it is impossible to select any single medium. A recent investigation has shown that the average individual spends only fifteen minutes a day reading the daily newspaper. On this basis any use of the news must be exceptionally distinctive and pointed to be of even passing interest to a reader group more fascinated by comics and daily scandal.

An educational precept well worth remembering is that found in Alexander Pope's *Essay on Criticism*. He says,

> Man must be taught as if you taught not,
> And things unknown proposed as things forgot.

To encourage dental health education in this manner takes consummate skill which requires sound knowledge of the basic principles of man's fundamental wants, for these wants constitute the prime movers of all his behavior. This can be accomplished only by awakening the dentist to the need for inclusion of courses on the science and theory of public health education in the curriculum of the various dental colleges, by devoting more time to graduate courses in this field,

and by demanding a greater part in the health affairs of the state. There are virtually no states in which there are any organized dental activities or dental personnel in the State Department of Education and only a few in which the dentist has a limited voice and an even more limited appropriation in State Boards of Health.

These objectives cannot be achieved in a short space of time, nor by periodic enthusiasms, but by constant and continued effort.

1405 *National Bank Building*
Jackson, Michigan

AWARDED PRIZE

Isaac Schour, D.D.S., Ph.D., Professor of Histology at the College of Dentistry of the University of Illinois, was awarded the Certificate of Merit, Class I, for his scientific exhibit at the recent meeting of the American Medical Association in Atlantic City.

Doctor Schour's exhibit was devoted to a study of tooth-ring analysis as demonstrated in the rodents and primates, as well as in the human being. The neo-natal ring, a line found in the human deciduous dentition, indicated the birthday of the individual. In other words, the tooth acts as a kymograph in recording the change from intra- to extra-uterine existence. With this in mind, Doctor Schour planned and executed his exhibit.

The physical layout of the exhibit was that of a semi-decagon. In the central panel the development of the human tooth was presented from its early embryonic stages to the stage of full development. By using a very intricate shadow-box and "flasher" system, it was possible to illuminate a painting of the successive stages of apposition. The other panels, which were devoted to experimental findings in the primate and rodent, gave proof of the definite rhythm in growth and calcification.

A similar award was granted by the American Medical Association in 1935 for an exhibit by Doctor Schour and Doctor A. G. Brodie, illustrating the effect of metabolic disturbances on the teeth.

Thirty Years of ENTHUSIASM

by V. OSTERGAARD

ONE RECENT AFTERNOON a dentist stood in his town's council room and addressed a group of farmers on the subject of electric power.

"It's Saturday," he said, "and I'm very busy, but I want to stay long enough to tell you that, if you get your project started, the village will meet you halfway—more than halfway."

The speaker, F. N. Thomsen, D.D.S., mayor of the village, paused briefly. "Of course we have a selfish interest in the possibility of selling electricity to your cooperative distributing system; but we're also anxious to help you obtain the benefits we enjoy here in Tyler from our power plant.

"And please don't believe the rumor that the plant can't furnish you with sufficient current. It can. The plant has three Diesel motors and only one is ever in operation . . ."

The mayor added a few more details in explanation of his council's attitude toward the problem of electrifying rural homes, wished his friends success, and reached for his hat and coat.

One of the men addressed him. "I'll be up in your office about three. That all right, Doc?"

"Yes, three o'clock is all right," Doctor Thomsen answered and left the meeting to return to the duties of a large practice.

This dentist—and mayor of a small Southwestern Minnesota town—spent his boyhood and youth in Nebraska, and was a graduate of Omaha Dental College in 1906. Soon after that he began to practice in Tyler, his home during the past three decades.

Now he's about fifty-six years of age, of medium height and weight, blond, blue-eyed, and friendly. Perhaps, as he walked to his office that Saturday afternoon, he took time to recall that he was now embarked upon a new adventure—aiding and encouraging the development of electric transmission systems in the rural areas. Perhaps not. For him, extra-professional activities are an accustomed experience. Through many years he has contributed materially to the growth of his community.

The community, in turn, has paid him the compliment of retaining a lasting impression of his active, many-sided personality.

The dentist's method of giving has been as forthright as the man

himself. He has had, still has, enthusiasm, and a keen interest in doing things. He pioneered and persisted in the cultivation of hobbies. Little by little those hobbies acquired devotees among his friends and a permanent place in the life of the community.

Now and then concrete evidence of this point develops—proof that thirty years of enthusiasm does produce results.

Take, for instance, the floodlights which illuminate the Tyler Tennis Club courts.

The summer evening was warm. A citizen of Tyler who had been away from his home town several years was watching two sets of happy players prancing about in the brilliant light blazing down upon them from high standards.

The homecomer turned to a friend. "Who put up the money for all this?" he asked.

"The village."

"Does the village furnish electricity, too?"

"Oh, yes."

"What about the floodlights down on the high school athletic field—does the village furnish current there, too?"

"Absolutely."

"That's fine. The council is really generous and up-to-date, isn't it?"

"Oh, sure; but, you see, Doc Thomsen is mayor now."

That was it, of course; a mayor friendly to community enterprise, a mayor who had, many years earlier, introduced tennis in a prairie village. Then a private citizen, he built the town's first court in his backyard and invited his friends in to play. Tyler's tennis club and longtime playing supremacy in competitive events followed quite naturally.

F. N. Thomsen, D.D.S., in his capacity as mayor makes an address.

Becomes a Producer

Doctor Thomsen no longer plays. Other interests absorb his time; but, in the same manner as his enthusiasm for tennis provided friends with a new diversion, so has he given direction and substance to amateur dramatic and musical entertainment in his community.

In this field, the month of August, 1931, faced him with something in the nature of a crisis.

The preceding winter a group of young people interested in music and drama had asked him to supervise the production of *Elverhoj* (The Earl-King's Mound) a light opera depicting life in the seventeenth century. Doctor Thomsen assented, surrounded himself with helpers, and began preparations.

Gradually the scope of his task became apparent to him. Production would require: approximately one hundred actors, singers, and dancers; a stage larger than any available within two hundred miles; seats for a potential audience of thousands; a full-sized, competent orchestra; a variety of costumes; money with which to finance the huge pageant; scene-builders; much publicity.

Wasn't it, after all, folly to attempt the presentation of a play in the Danish language, a play which had been shown only once before in the United States, and then in a city where facilities of all kinds were more readily available?

Possibly, but Doctor Thomsen had committed himself.

Summer marched on. During the day, the dentist-director stuck to his office. When the sun flamed red in the west, he marshalled his cast for rehearsals. The orchestra practiced difficult scores faithfully. Scene-building, costume-making, publicity progressed. Production of the opera was well on its way to becoming an accomplished fact.

Yet steady progress would have been impossible, success unattainable, had not the dentist's co-workers been trained. But they were trained amateurs. Their director had trained them —a long, slow, patiently performed task which had stretched through the preceding years.

In the beginning Doctor Thomsen was only a self-taught violinist. Except for a few early lessons from his father who taught his son to love music, and two brief periods of formal instruction, Doctor Thomsen had gained his knowledge of music through playing, through instructing others.

He organized a string quartette which rehearsed in his home evenings and Sunday afternoons. The quartette became a sextette, then an octette, and finally a full-sized orchestra, which appeared as often as there was a demand for music at public and semi-public functions in Tyler and in neighboring villages.

Leadership of the organization passed from the dentist to one of its members, the public school's music teacher and band and orchestra leader.

But, while the dentist had been building an orchestra, he had also given much time to play production. Year after year, amateur actors under his direction appeared in stock high school sketches, Broadway successes, old Danish plays in the Danish language, operettas, farces.

He drilled and directed choruses, mixed and unmixed, big and little, and always he insisted upon quality plays, songs, music, and performance. To him the mediocre was intolerable and only a performer's best effort acceptable.

When, therefore, *Elverhoj*, a perennial favorite in Denmark where it is produced by professional actors, presented difficult problems, solutions appeared

Doctor F. N. Thomsen at his home work bench where he designs furniture inlaid with grained and finished woods.

simply because the director and his troupe were more thoroughly at home in their arts than are amateurs of most localities.

Doctor Thomsen's production of *Elverhoj* is history, a beautiful, inspiring bit of history for those who took a part in presenting this romantic, old-world opera on an outdoor stage in the outskirts of the village to the thousand-odd spectators who came from near and far. For many of them, too, the spectacle will remain unforgettable.

But should this one episode in a busy man's life seem of less and less importance, still his influence —of which the production of *Elverhoj* is a symbol—will continue to be significant.

Put it this way: Doctor Thomsen gives less time to play production than he once did, but he is a sort of Director Emeritus and arbiter of quality although he may not be consulted in the choice of a play and asked to direct it, still the standards he maintained are a mark at which others may aim.

Back of the dentist's house is a garden where vines climb white trellises and flowers bloom among curved walks and collections of oddly shaped rocks and delicately veined field stone. The garden and rock collection represent a private adventure; yet the Thomsen residence is something of a show place to which friends bring friends to admire the owner's latest achievement.

Possibly the man's enthusiasm and skill here, too, have been a community factor. His influence cannot, however, be traced so definitely as in several other leisure pursuits; but it is certain that homecraft and gardening have become strongly entrenched pastimes among his fellow citizens.

The most recent general expression of interest in this direction is the establishment of an industrial arts department in the public school.

Characteristically, Doctor Thomsen is a pupil at the blacksmith's forge.

Tyler, Minnesota.

GOING, GOING—

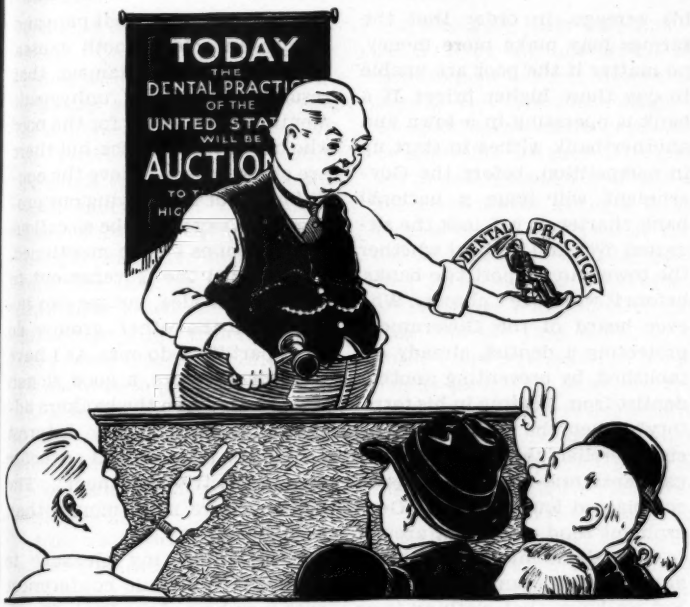
by C. B. WARNER, D.D.S.

ANY METHOD WHEREBY one may receive dental services for less than a legitimate fee represents a form of chiseling, and no matter how or where a dentist lives, he is injured by it for it limits the dental field.

This evil has been with us from the beginning of the profession, and, until lately, has been bitterly fought by the dentists. At first it appeared in cheap dental "parlors" and advertisements for home treatment. Then the colleges began dental clinics giving services at the cost of materials. There were objections, but the necessity for education was so great that the clinics were condoned. Then the Government stepped in with free army and naval dental service and clipped off a generous slice of territory. Next came marine hospitals with free dental service for boatmen. Then followed private clinics like the Eastman and Forsyth. After that, certain large manufacturers established dental clinics for their workers. Then the States came in with some free prophylactic work for school children, and the cities began to operate clinics for their poor. Now the Federal Government has started a mass production in earnest. All this is chiseling in the dental field.

The last few issues of ORAL HYGIENE aptly illustrate our headlong descent into the field of socialism, and we dentists might just as well begin to put our house in order to quit the field in time. I have not mentioned health insurance or cooperative hospitals, which are also cutting into the dental field. We are raising a crop of middle class people who consider it a great wrong, if they are forced to go to a dentist and pay a real fee. As long as they have votes, the politicians will see that they will not have to do this. If they have some official position, or are in any way helped by the Government, they are in line for free dental services. If they do not fall in that category, there are plenty of local or private clinics to assist them.

Many dentists delude themselves into thinking that with federal operation they will fall into fat jobs. If they will only consider that about four-fifths of the dentists will be out of work, and those with a good pull will be on the inside, then they will be closer to the truth. The Government, with its burden of debt, has not the money to employ a large number of dentists with good salaries. Mass production will mean *cheap* dental work in both meanings of the term. In steel production, if the price falls, some of the mills are closed by the trust until



the market picks up. In dentistry, there is no such protection. Our colleges grind out a new crop of dentists every year regardless of market conditions. Our young college graduates, pouring out by the thousands into a market closed in other lines by the depression, see an open field in dentistry.

If a high salaried government official employed under the Social Security Act, comes to a dental convention with a program for free dental aid to the poor, he is wined and dined. If that same official went to a banker's convention and asked for free interest for the poor, or a reduction of a measly 2 per cent, he would get no results. When the Lemke Bill was up to permit farmers to borrow direct from the Government on good security, what did the bankers do? You know what they did.

Goverment Aids Some

Does the Government take as much interest in aiding dentistry as other occupations? I can answer that by a few examples. Food is as necessary as dental service. Suppose that the Government started some large farms, with the latest machinery, and raised food for the poor and gave it away, what would happen? Instead, the Government virtually compels each farmer to *cut down*

his acreage, in order that the farmer may make more money, no matter if the poor are unable to pay those higher prices. If a bank is operating in a town and another bank wishes to start up in competition, before the Government will issue a national bank charter, it will look the situation over and find out whether the town can support two banks, before it will issue a charter. Who ever heard of the Government protecting a dentist, already established, by preventing another dentist from locating in his territory? When the CWA wished to employ relief labor to make men's garments and the big factories complained loudly, did the Government send an official around to talk them into it? Not that anyone knows anything about. Yet we know that clothing is as essential as dental services.

We have no *free* Government stores. Even those stores which could give the poor some relief, like the chain stores or the big mail order houses, came in for heavy taxation, and were told that they must keep prices up.

No, it is the dental profession that must carry the socialistic load, and the peculiar part about it is that often it is our leaders that aid and abet this coming destruction of a great profession. Of course, our leaders are mostly men of large incomes so they are not affected. True, we have some long society papers, and we gather up tomes of statistics, but anything that might cause friction we studiously avoid.

Now we all know what pain and torture an aching tooth causes. We also know the damage that results from an unhygienic mouth. We feel sorry for the poor who need dental service, but there are other ways to relieve the condition besides destroying our profession. We need not be as callous as the groups I have mentioned, who compel the Government to accept their idea, but we can insist that the other groups do their part if we do ours. As I have mentioned before, a good slogan might be, "When the bankers advocate loaning money interest free to the poor, we will advocate free dentistry for them." The bankers have more money than dentists anyway.

It has been my pleasure to have had economic conferences with members of the Brain Trust, with labor, farm, and industrial groups, and I can personally state that their opinion of our ability to stand up for our rights is low. They protect their own interests by means of highly paid lawyers and economists, and they leave it to the officials to take care of the poor rather than sacrifice their own interests.

To some it may appear that I am unduly alarmed. Possibly, but if we do not make better progress in the future in protecting ourselves than we have in the past three years, when we first began to rail at panel dentistry, we will soon find out if my concern was premature. Some time ago I saw a significant cartoon in a magazine devoted to the clothing

trade. It represented a snake labeled "Government Operation" rising with its jaws open, in the shape of a wedge, ready to snap at a morsel of food labeled CWA. It referred to the government proposal to manufacture clothes with relief labor. The cartoon was entitled "The Opening Wedge." As I have mentioned before, the clothing trades fought this thing to a finish and it never proceeded any further. Perhaps they were unduly alarmed also. If we were to present that same cartoon in its relation to dentistry, we might picture the same snake with a bulge just below its throat and give it the title "Going, Going—."

Now as to what can be done about this serious situation into which we have already been precipitated, there may be several remedies. My suggestion is a simple one based on the attitude of the stores in their handling of relief. They will not permit the Government to come into a community and give goods away, or to open stores where goods will be sold below the prevailing market prices. Instead, they insist on the Government giving a larger income to the poor so that they can afford to buy, without upsetting the trade. If the Government would set aside five hundred million, or twice that much, to be given relief agencies for purely dental care, with moderate fees required for the local dentist who does the work, no special equipment would be necessary and no inroads on dentistry. However, we may expect little relief from these ills since the dental profession does not garner its political strength, and does not appear to care what happens.

Yerger Building
Biloxi, Mississippi

The Fine Art of DICHOTOMY

by S. J. LEVY, D.D.S.

A NICE WORD THIS, *dichotomy*. The very sound of it implies a specialty. You never came across it back in the university? You must be an old timer. The chances are about eight to one that you are practicing it nevertheless. Dichotomy, in short, is the fine art of one physician referring a patient to another physician for a price. Fee-splitting? Now you are talking.

This universal dichotomy epidemic has held the medical profession in its grip for a number of years and has baffled its greatest specialists. They groan and cringe in pain, yet all they can do is let the disease run its course unabated.

Physicians know of patients who prefer to hold on to their diseases, resisting a cure. Dichotomy is the physicians' own disease—they would not let go for anything in the world.

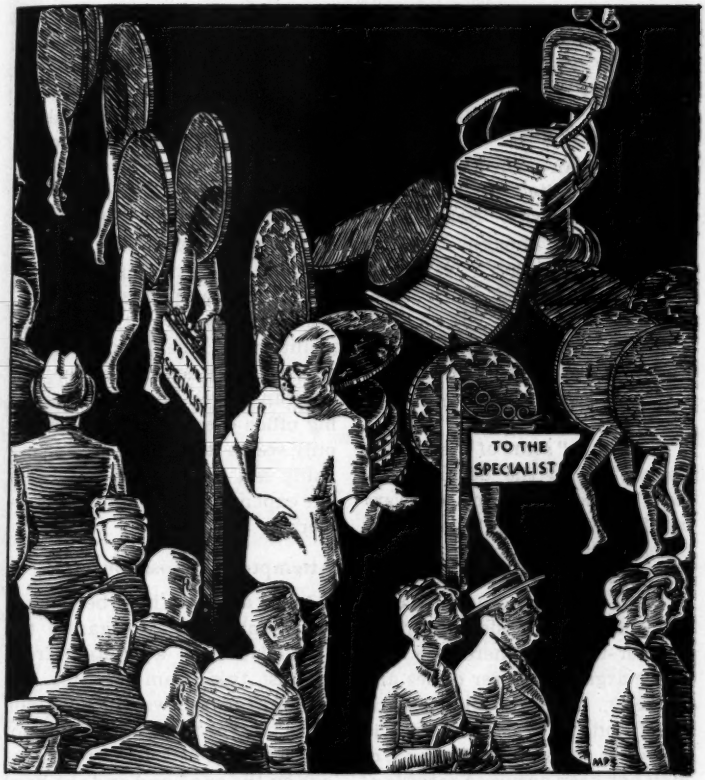
According to Doctor Harold M. Hays, prominent New York physician, 579 out of 770 doctors in Kings County Medical Society, voted "against establishing a law to stop the practice."

It must be good if they themselves believe in it. Physicians ought to know. Doctor Hays, in *Time*, February 8, 1937, gives a clinical history of one case symptom: "About a year ago a Bronx doctor called me. He said he had a case of mastoiditis, a child, and would I operate. This was on a Saturday, and the doctor suggested that the operation be performed the following Monday. I asked what temperature the child had. He said 103°. I told him that he must be crazy if he didn't think the operation should be performed right away. 'Well,' said he, 'we have to make an arrangement.' The 'arrangement' was that he wanted me to charge $1,000 for the operation and offer him a substantial portion. Over the week-end he was going to persuade the child's family that $1,000 was a fair price."

Medicine is the father of dentistry, and what an apt pupil its offspring proved to be. It can teach father a thing or two.

Oral surgeons of reputation and great skill, who refuse to be modernized, sit idling time away in their deserted offices, while the younger men with less knowledge but more adaptability to the new science of dichotomy are raking up the harvests.

This happened in one of the greater New York boroughs. A patient with a fractured maxilla,



"Oral surgeons of reputation and great skill, who refuse to be modernized, sit idling time away in their deserted offices, while the younger men with less knowledge but more adaptability to the new science of dichotomy are raking up the harvests."

an emergency case, came to a neighboring dentist. The dentist got busy making the rounds of specialists by telephone. The market kept fluctuating over a hot wire. The patient was finally shipped to the highest bidder, who got $100, which he split fifty-fifty with the dentist. Two days later an ambulance delivered the patient directly to the operating room of a hospital. Some weeks later he was discharged, disfigured, but luckily alive. He instituted suit for $50,000 against the specialist with a bona fide case of malpractice. The interesting sidelight of the story was the dentist

of the original sin. He went around among his colleagues grinningly boasting. "I'm out of it, and I got my fifty bucks."

Behind the Scenes

It is now an open game. Dentists are solicited by telephone and personal visits. "Hello there. Passed by and thought I'd drop in to ask why I don't hear from you. Wasn't the last check satisfactory? Why don't you say so? You know that I'm fair. Tell you what I'll do, I'll let you make the price, anything you say's okay with me."

"Accounts," some of the periodical letters to the dentists say, "are balanced the first of every month." It is enough to make any hungry dentist's mouth water. Checks are drawn to cash, signed by some unknown name, that of the specialist's assistant or his brother-in-law. There are frequent arguments over dimes and quarters, because the general practitioner has become wise in the ways of finance. He may or may not keep accurate records of work done on patients, but he keeps a careful account of the items sent to the specialist. Discrepancies, however, are cheerfully adjusted by the payer, over a lunch counter at the expense also of the giver, as a good measure. The oral surgeon merchant knows that "the customer is always right."

The dentist often sends cases out he could very well do himself. Says one: "I can't collect $2 for an extraction, but when I send the same patient to my specialist he gets $10 and sends me $5. I don't know how he does it, but he does it."

There is no great secret about the method of extracting money. Antrums are unnecessarily opened, simple extractions are exaggerated into complicated operations, "necessitating" curetting, suturing, dressing, and many visits for "treatments."

Great have grown the "responsibilities" of the burdened specialist. There are heavy liability insurance premiums to pay and a big office overhead. He must not only see to it that there is something left for himself but carry the expense burden of his patronizers.

Attempted Opposition

Many attempts have been made in recent years to organize the specialist into a united front against this sham practice, but all efforts are in vain. Those who have tried it for a time could not endure long. The loss of patronage on the one hand and the howl raised by the customers who had included this easy income in their meager budgets were more than they could withstand.

Says the specialist: "I admit it is a nuisance and a sham, but the dentist demands his rebate and I have to give it to him or he will send his patients elsewhere. It is not up to me."

Says the dentist: "Ethics? Boloney. That check on the first of the month comes in very handy."

Societies forbid the practice. It

is immoral and indecent. If a law were passed against it, would it check the practice? Remember the eighteenth amendment. What weight can there be to law, morals, and decency on one end of the scale against a nice little check on the other end?

1230 *Sheridan Avenue*
New York, New York

DENTAL CLINICS SERVE INDIGENT

Within the past eighteen months hundreds of thousands of children have passed through WPA dental clinics in many states for examinations, treatment, and instruction on the care of their teeth, according to a report issued recently in Washington. Adult clinics have also been maintained efficiently as part of the public health program operated under the supervision of Federal and State public health services by the Works Progress Administration.

The staffs of these clinics have been recruited from the ranks of dentists and nurses who, through the loss of their private patients during the depression, were forced onto relief rolls. Wherever possible these professional workers have been attached to existing medical clinics or incorporated in school hygiene programs. When conditions warranted them, however, special dental clinics have been set up in thirteen states. This is a continuation under the WPA of the work done by the original Federal Emergency Relief Program.

As an illustration of the wide distribution of dental service, New York City is mentioned in the report. In 106 clinics there are 176 dentists employed. Since August, 1935, 386,000 children have been treated in these clinics.

Adequate personnel to maintain the dental clinics is available from among the 11,443 physicians, dentists, and nurses who are employed now on WPA health projects. Thus, although the need for dental service among the destitute is still great, the dental departments of the clinics will continue to function effectively as long as necessary.

WHAT *Shall I Do With My* MONEY?

PART II

by G. J. JAMES, D.D.S.

LAST MONTH WE discussed the financial problems of dentists whose ages ranged from 25 to 45. In this article I wish to make some practical suggestions for those dentists who are past 45.

GROUP III

Age 45-55

In practice 15-25 years

This group has felt the depression keenly. Many men in it are now compelled to give up ideas of retirement and must continue practice. They have reputations, established practices, and perhaps a few assets which must be conserved for the years when physical reserves will be decreased. Some men in this group are more than discouraged. They have planned and worked a lifetime in order that they should not become dependent upon others for their livelihood. They have worried themselves into ill health and, in their fight to save as much as possible, have weakened their physical reserves seriously. The families of these men are approaching maturity (college age) and the dentist-father feels the responsibility most keenly. Their future, as well as his own security in old age, hinges on his management of his financial affairs during the next few years.

Subdivision a

In deciding a proper course of action in respect to the future, the general group should analyze their circumstances as follows:

1. Total assets and total liabilities. Separate office and personal liabilities into two distinct lists.

2. Review budgets of household and office based upon present standard of living and services rendered.

3. Analyze gross income during the past two years to determine, if possible, how much it can be improved with additions in either equipment or service.

Note: Based upon an active practice life of ten or fifteen years more, answer this question: "What investment can I make in my own business which will increase my gross income sufficiently to return the principal of such investment, pay 6 per cent return on the money so invested while producing during that period at least my minimum hourly fee?"

Many of the generalities in the concluding portion of these articles may be adapted to this particular group of men who have a

definite practice-life expectancy of ten years or more. For younger men we have advocated the principle of investing in their own businesses as a primary course of action. In this discussion, however, the individual so affected must analyze his personal position with respect to the future. He cannot gamble and take chances with his hard-earned money. He must also give thought to the next period of his life when he will need a definite income from some source of investment with which he can supplement his declining professional remuneration.

This first division of this main group should give attention to the following items:

1. Completion of obligation on the home.

2. Rounding out the insurance program to include paid up annuities where possible.

3. Careful systematization of savings for cash reserve.

Note: The reinvestment of these funds should be made on a basis of safety of principal and consistency of income. Funds which are received from the sale of investments, from dividends, and profits from real estate held for investment purposes, should be paid directly into this account which is segregated in a special savings account in the local bank. The government now guarantees savings in banks up to $5,000 so that cash can be accumulated up to this amount with a feeling of reasonable security.

In the latter section of Group II we discussed the beginning of an investment program. In the present instance this program is now in full operation.

Subdivision b

In this next section of Group III are those men who are within two or three years of the age limit for the group.

From this point on they should be able to gather the benefits of their work but, because of the depression, some who thought it would be possible to do this, dare not cut down on their activities in practice because of various personal reasons. Most of these men have active practices at this period. Probably their last investment in their own business has been made. Their one purpose from a financial point of view is to continue satisfying their wants from their earned income. They must centralize other investments so that, when the necessity for a supplementary income from outside sources presents itself, they can call upon their reserve with a definite feeling of future security.

I do not mean to infer that dentists are "through" at fifty-five. Far from it. However, it is a fact that the years which follow this age are more likely to present physical strains which previously were not a serious factor. This necessitates loss of time from the office as well as a drain upon resources if the dentist is unprepared for such emergencies.

Since we are discussing those dentists who are nearing the border-line of this classification of

Group III, let us move on to the next section. Here these men may find a solution to their problem; particularly if a reserve for future years has not been accumulated.

GROUP IV

Age 55-65

In practice 30 years plus

This division has long interested me because I have known some fine persons who fall within its limits. I must say, too, I have seen others who were really pitiful. Some were fresh and optimistic, the others cynical and pessimistic, dwelling primarily upon past mistakes. That the difference was in point of view is only too true. An enthusiastic exterior is always more appealing than one which presents a perfect picture of discouragement. Such a statement is applicable to all the divisions we have made, but its application is a little different. Youth has resiliency. Age and unfortunate experiences create doubt, especially when former patients are attracted to the younger men's offices and are casually observed going there steadily.

The younger practitioner should take heed of his position. Some day he will be in Group IV. He must plan accordingly, otherwise he will be the discouraged one we have described.

Many older men carry on daily. Some have to, as I pointed out. Others are letting down, supplementing their reduced earnings with the income from their remaining assets. Indeed the individual is fortunate who can so "fill in" his lessened income. The tragedies of practice are those instances in which practitioners have become physically incompetent yet must continue in some manner to eke out a livelihood from what was once a thriving practice.

Fortunate, too, is the dentist who can see his son following in his father's footsteps in the selection of a profession. Here is an element of security for both. The father's established practice gives the son security when he is in Group I c and II a, whereas the son returns the compliment when his father is in Group III b and Group IV. The technique of open-mindedness must be carefully cultivated by both dentists so situated. The experience of the one is a valuable asset to the younger man. He can profit by it if he wishes to. He need not sacrifice ideals or hopes in listening to its teachings. The older man finds the fresh enthusiasm of the younger a source of inspiration. Both should stand better united than either separately. Each should draw a definite income from the office. When the senior has completed his practice-life, the junior carries on the practice. It is intact and he has earned it. Here I might suggest that it is sometimes a good idea for an older dentist to take a young man, even though he is not his son, into his practice. It creates a feeling of security and permits the older man to enjoy more relaxation.

Today there is an ever increas-

ing tendency to buy life insurance as an investment for our declining years. These sums are paid after the contract has been fulfilled. It means that a larger lump sum of savings is made immediately available.

Wise is the dentist who takes his payment as a regular monthly income either for a period of years, or in the form of a life-income annuity. To invest the whole of such an amount in a stock of "sure possibilities" is foolhardy at this stage.

This time of life calls for safety of procedure more than in any other period. All financial technique should be directed toward the central focal point of supplementary income.

To concentrate assets in some liquid form and income producing medium should be the aim of the immediate members of Group IV.

Conclusions

In conclusion I want to say that if the reader hoped that these articles would yield a method of "making money easily," I'm sure he was sadly disappointed. Such prescriptions are dangerous concoctions. Lethal doses are easily taken, but the pain of remorse lasts a long time.

If the standard of living during the earning years is expanded beyond proper individual limits, it becomes necessary later on to sacrifice one's security as a result.

It might be helpful here to tabulate a general summary of our discussion as follows:

(a) Separate office affairs from personal ones. Pay yourself a weekly salary. Base this figure on facts. Use all available records to arrive at a fair figure. By treating yourself as an employee of your own business, you will acquire a different perspective of the business.

(b) Analyze your services. Have you eliminated anything during the depression which is now a handicap to your rendering a capable service?

(c) Analyze your assets and liabilities carefully to determine your financial position exactly. Separate office and personal problems again.

(d) Groups I and II may have obligations left over from the depression or some other misfortune. These should be listed in one amount. Pay only a fair rate of interest for the privilege. It can be done in many ways. The choice is an individual problem. The principal should be returned by monthly payments of a size that will assure their regularity. Faster payment than agreed upon is, of course, desirable.

(e) Resolve to study and devise adequate methods of keeping necessary records relating to both office and private matters.

(f) Investment and estate building or retirement programs may be started early by means of insurance. This will mean protection for early ventures and may be adapted to any other program later on.

(g) A cash reserve account is a

desirable feature of every investment account.

(h) A home is a good investment in many ways, provided it is not a more expensive one than the dentist can afford.

(i) As a rule vacant property is a poor investment because taxes and interest may rob the would-be-investor of his profit.

(j) Government bonds are a safe medium for one whose money comes as hard as does that of a dentist.

(k) Bonds of sound corporation are recommended if investigation proves their worth.

(l) Common stocks of good corporations are permissible if purchased outright and are never allowed to amount to more than twenty per cent of total assets.

I have tried to stimulate thought toward the objective of "Supplementary Income." Of necessity, generalizations have had to be made since each one of us offers a different combination of circumstances surrounding our economic existences. Dentists do not expect to manage large corporations, build railroad empires, or engage in major political battles. Our position in society is definite and to keep it always well balanced and protected against factors beyond our control should be the aim of each one of us.

9400 *Euclid Avenue*
Cleveland, Ohio

EMERGENCY LEGISLATION IN WISCONSIN

An emergency measure recently passed by the Wisconsin legislature and signed by Governor LaFollette gives all licensed dentists in that state the right to use the title, "Doctor." Necessity for this legislation first came to light during the trial of a malpractice suit in one of the local civil courts in Milwaukee. The attorney for the plaintiff brought out the point that dentists in Wisconsin were not entitled to use the title, "Doctor," basing his statement on a Wisconsin statute.

Because of the importance of this matter to the dental profession, the Wisconsin Dental Society with the aid of an attorney immediately investigated the question. As a result, a clarification measure was drafted for the purpose of amending the statute in question. The provisions of the new legislation have now been made a part of the state dental law. In the future there will be no question of the right of all licensed Wisconsin dentists to use the titles "Doctor," and "Doctor of Dental Surgery."

Twenty Do's *and* Don't's *for Dentists*

by A VETERAN PATIENT

"TRIFLES MAKE PERFECTION, but perfection is no trifle." For the last twenty-six years I've been trying to find a really satisfactory dentist—one who gives attention to the little things as well as the big. The suggestions below are made with the hope that they will serve to eradicate those minor sins of omission and commission which have been factors in influencing me to change my dentist several times.

I want to make it clear, however, that I'm not a crank, but just a normal human being who is perhaps a little more observant than the average patient. My suggestions follow:

1. Change the paper drinking cup while the patient is in the chair, so he can see you do it—he may have a phobia against using the cup of the previous patient. One of my former dentists always had a paper cup ready in the holder. I presume it was a fresh one but I would have liked it better if I had *seen* it taken from its glass receptacle.

2. Be businesslike—concentrate on your work and don't discuss the stock market or politics. The same dentist frequently discussed the activities of the socialists and communists, thus disclosing where his sympathy lay; a risky thing to do when the political affiliation of the patient is unknown.

3. Wash your hands before starting work on the mouth; also every time you finish talking on the telephone if you are inter-

At least two minutes elapsed before he found it, after looking in about a dozen drawers in the cabinet.

rupted during your work. One dentist I visited always neglected the latter, and this didn't increase my confidence in him.

4. Don't discuss the patient's teeth with anyone else in his or her presence; that patient may have a sensitive nature. I remember one dentist calling me in the operating room to see what he thought would be to me an interesting mouth. The patient, a young lady, was quite embarrassed.

5. Be familiar with the location of your instruments. While I was having an extraction of a rather difficult molar, it was necessary for the dentist to use an instrument which was not already on his tray. At least two minutes elapsed before he found it, after looking in about a dozen drawers in the cabinet.

6. Don't become excited if an extraction proves to be more difficult than you anticipated. It doesn't impress the patient with your ability, and in most instances will cause alarm unnecessarily. I had this experience with one dentist but fortunately I am of a calm temperament. However, another patient may easily become alarmed.

7. In every extraction, inform the patient before he leaves where you can be reached in the event of an emergency. Several hours after I had an extraction a hemorrhage set in and I was unable to communicate with the dentist. Fortunately a physician residing in my apartment house stopped the bleeding.

8. Never dismiss a patient with an ill-fitting denture, and never show annoyance no matter how many times the patient has to return to have the denture adjusted. I changed dentists because of such an experience. Even after several adjustments I simply couldn't use the new tooth, for which I had paid $60. My dentist's ill-concealed annoyance at the failure of the tooth to fit properly discouraged further visits. The result was I became disgusted, sold the tooth as old gold, and quit that dentist.

9. Always look clean. Your hair should be neat and your face shaved. It is important that your fingernails be short and clean. (On one occasion the long fingernails of a dentist cut into my lip).

10. Change your white office coat every day; don't wait until it begins to look soiled. Most people are germ-conscious nowadays.

11. Be sure your equipment and working tray are dustless and your windows and curtains clean. Patients' eyes wander as they sit in the chair, and everything they see registers either favorably or unfavorably.

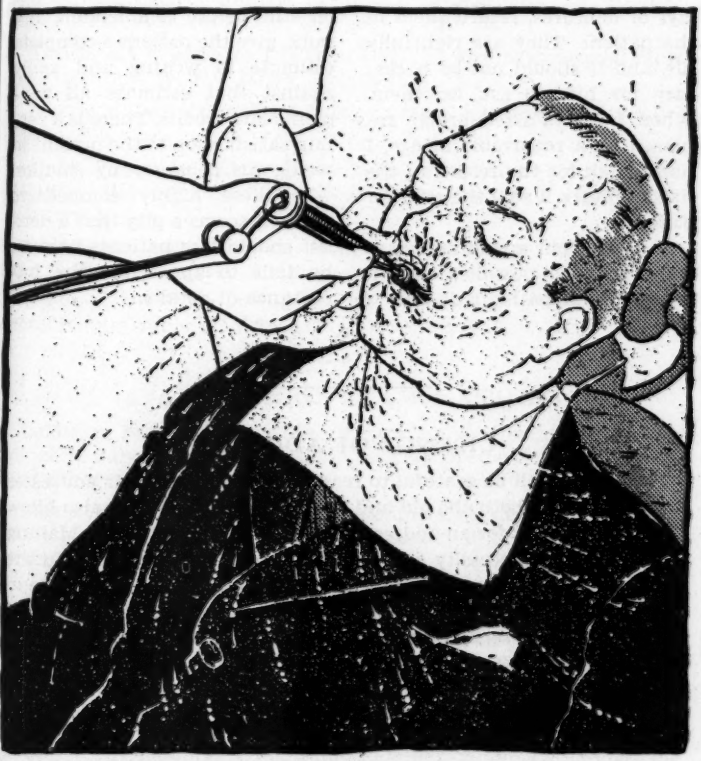
12. Keep your office and particularly your desk tidy. If your office is in a dusty neighborhood it should be dusted more than once a day, especially during the hot months when the windows are wide open. An untidy and dusty office is never attractive and creates a doubt as to the sterility of your instruments.

13. Fasten the towel you put around the neck of the patient

with clips, otherwise it slips easily. And don't wipe your instruments on this towel. This was a habit of a dentist which always annoyed my wife, who was afraid of her dress becoming soiled.

14. If you are going to do a prophylaxis and polishing with pumice powder, cover the patient's suit with a large cloth, as the pumice flies when the polishing wheel is used. One thoughtless (or perhaps lazy) dentist cleaned my teeth without taking this precaution with the result that I spent half an hour removing the dried powder from my suit.

15. Change the headrest cover as soon as it becomes soiled. No one wants to put his head on a rest that isn't perfectly clean.



". . . with the result that I spent half an hour removing the dried powder from my suit."

The ideal would be to have a clean cover, paper or otherwise, for each patient. Dentists would do well to follow the lead of the modern barber shops in this.

16. If you have a nurse, don't "kid" her while the patient is around. A dentist I knew did this frequently. It created an unfavorable impression on me, as I am sure it must have on other patients.

17. If you remove any gold inlays or dentures, return them to the patient. They are rightfully his, and it should not be necessary for him to ask for them. When I had a fixed bridge replaced by a removable bridge, I had to ask for the return of the fixed denture. I sold the gold for $5.00.

18. Keep your appointments as punctually as possible, even if some of your patients do not. If it is a six o'clock appointment, make every possible effort to be ready at six, not 6:15 or 6:30; the patient may have an important engagement the same evening.

19. If the patient is delinquent in his payments, only one—the dentist or the nurse—should mention this to him. For both to do so might arouse resentment.

20. Give the patient a receipt for every payment made, whether you receive cash or a check. Better still, before commencing any work, give the patient a complete estimate in writing and apply against that estimate all payments and credits. There is a certain satisfaction to the patient in seeing his debt getting smaller.

In these highly competitive times, it seems a pity that a dentist should lose patients because he fails to appreciate the importance of details.

CHANGE OF ADDRESS

ORAL HYGIENE will be grateful to readers who change their addresses if they will send both the old and the new address. Please also allow at least two weeks for an address change to become effective. Mailing wrappers are of necessity addressed two weeks or more prior to the publication date; hence when your address change reaches us late in the month preceding publication it is often impossible to make it effective before the second month following.

DENTAL MEETING DATES

American Academy of Periodontology, twenty-fourth annual meeting, Claridge Hotel, Atlantic City, New Jersey, July 8-10.

Pan American Dental Conference will be held on Saturday, July 10, at four o'clock. Rose Room, Chelsea Hotel, Atlantic City.

American Dental Assistants Association, thirteenth annual meeting, Chalfonte-Haddon Hall, Atlantic City, New Jersey, July 12-16.

American Dental Hygienists Association, annual meeting, Atlantic City, New Jersey, July 12-16.

American Dental Association, annual meeting, Atlantic City, New Jersey, July 12-16.

American Society for the Promotion of Dentistry for Children, Hotel Chelsea, Atlantic City, New Jersey, July 12.

Association of American Women Dentists, sixteenth annual meeting, Atlantic City, New Jersey, July 12-16.

American Dental Society of Europe, annual meeting, Paris, France, August 2-5.

Alpha Omega Dental Professional Fraternity, Ritz-Carlton Hotel, Atlantic City, New Jersey, July 12-16. An attendance of 150 members is forecast.

Ohio State Dental Society, seventy-second annual meeting, Mezzanine Floor of the Neil House, Columbus, November 8-10.

Greater New York Dental Meeting, thirteenth annual meeting, Hotel Pennsylvania, New York City, December 6-10.

STATE BOARD EXAMINATIONS

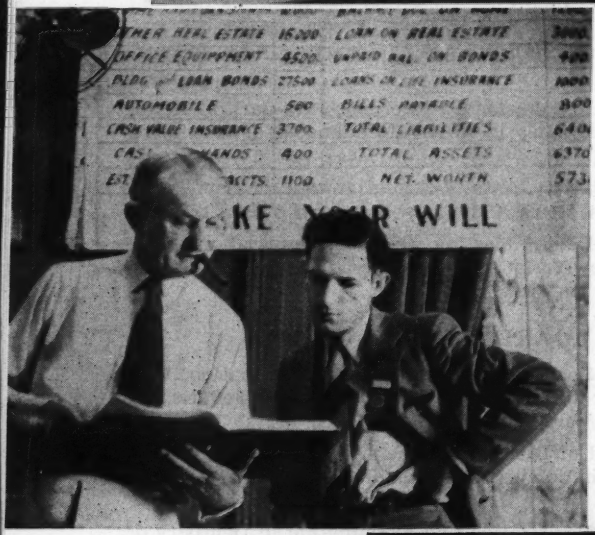
Delaware Board of Dental Examiners, annual examination, Wilmington, July 7-9. For information address Doctor C. R. Jefferis, 409 Medical Arts Building, Wilmington.

North Dakota Board of Dental Examiners, Gardner Hotel, Fargo, July 12-15. For information write to Doctor W. E. Cole, Bismarck, North Dakota.

The State Board of Registration and Examination in Dentistry of New Jersey will hold its annual examinations, commencing Monday, December 6, and continuing for five days thereafter. Upon application to the Secretary, Doctor Walter A. Wilson, 148 West State Street, Trenton, a copy of the Requirements and Rules, Instruction Sheet and Preliminary Application blank will be sent. Applicants must file the Preliminary Application, together with the examination fee of $25.00, on or before September 1. For June examination applicants must file the Preliminary Application, together with the examination fee of $25.00, on or before March 15.

SHOTS FROM TEXAS

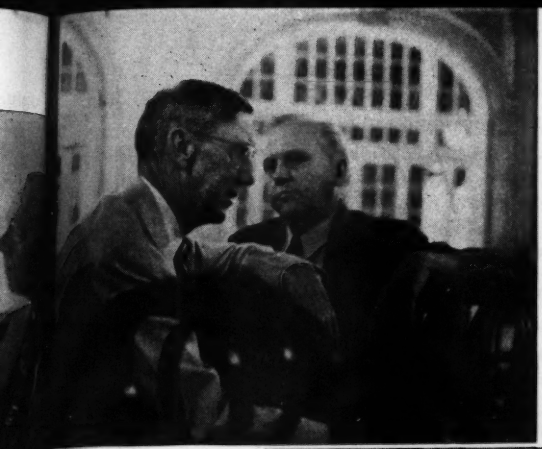
By Camera Man Lewis C. Turner, D.D.S., San Antonio.



President A. L. Nygard of Dallas (above) presides at the Texas State Dental Society Meeting held in the Rice Hotel, Houston, May 17-20, 1937. At the right is the temporary secretary, J. R. Tipton. Second from the left is Past-President W. P. Delafield.

After the clinic is over, J. A. Schubert of Alice (above) interviews the instructor C. R. Laurence of Enid, Oklahoma.

Floyde Eddy Hogeboom, Los Angeles, presents a lecture on "Fractured and Injured Incisor Teeth of Children."



Whether talking of bird dogs or dentures, F. M. Hight of Houston (left) always has attentive listeners.

President-Elect E. Berwick of Austin (left) and S. R. Parks of Dallas attend a session of the house of delegates.

San Antonio, in 1938!

Editorial Comment

GIVE ME THE LIBERTY TO KNOW, TO UTTER, AND TO ARGUE FREELY ACCORDING TO MY CONSCIENCE ABOVE ALL LIBERTIES. *John Milton*

SEEING OURSELVES AS PATIENTS SEE US

WE HAVE ALL known skilfull dentists without profitable practices and mediocre or inferior dentists with large practices. Usually we chalk up the failure of one and the success of the other to what is popularly called "personality." Personality is difficult to define: it is both a positive and a negative entity; it may be compelling and attractive; it may be repelling and unattractive. The personality commonly referred to in association with successful dental practice is a subtle blend of attributes. It is not intelligence alone; it is not good looks. There is no set formula by which to acquire it; there are no rules to be memorized and practiced which will guarantee it. Personality is not expressed by fawning over patients or by arrogant superiority.

Personality is the reflection of the total person: his ancestry and heredity, his childhood, his education, his disappointments, his fears, his conquests, his hopes. His surroundings, his associates, his physiologic ebbs and flows influence it. It is an intangible, composite picture which evolves slowly. Routine measures, reading best-sellers on how to get along with others, short courses in so-called psychology may help us. Often, however, such broken doses of glibness are irritating, sometimes ludicrous.

The close personal nature of the dental service requires that the dentist have the ability to get along with other persons. There is nothing impersonal about dentistry. A person has a highly individualistic expression of some form of a disease of great concern and interest to him. Another person, the dentist, by his ministrations must treat this disease as a unique condition unlike any other he has ever treated. No two dental patients ever have precisely the same disease condition; no dentist can treat any two cases alike. Nor, for that matter, will any two dentists use the identical technique for such a simple procedure as an occlusal amalgam restoration.

In addition to the individuality of his disease the patient has fears,

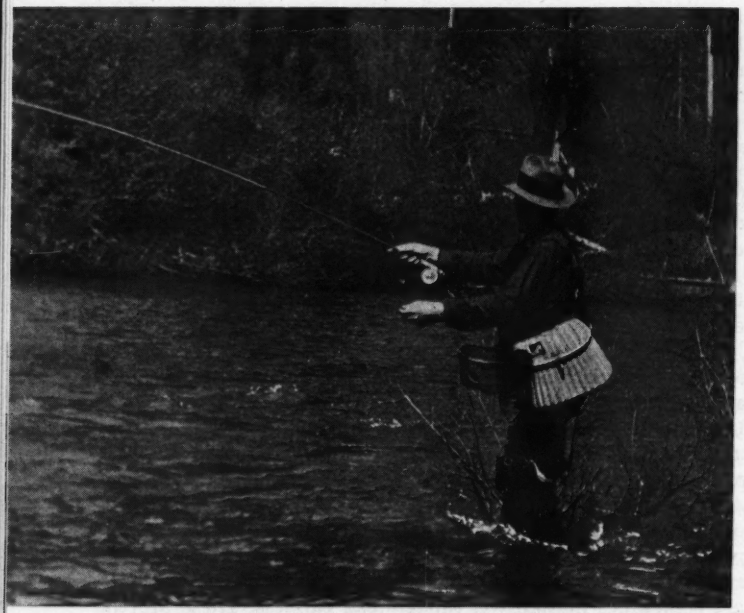
preconceptions, and misunderstandings of the dental experience. In treating that patient's dental condition the dentist must also uncover these psychologic states and overcome them as he proceeds with technical treatment. Whereas caries, for instance, can be treated by a direct, frontal attack, the psychologic states are approached and overcome more circuitously. Fear cannot be extirpated with a sharp instrument. It is exposed and removed by more subtle therapy. This requires an understanding of the behavior of personalities totally unlike our own. This kind of understanding is what patients want and expect from their dentists. The dental patient expects to be treated with the uniqueness that his disease and his personality require. The dentist who blunders through and attempts to treat every condition and every person alike may have a great technical skill. Usually, however, he has nothing else.

Most of us are irritated by those who "spray personality" about them; who grin and chatter, back slap, paw, and grip hands. These fixed poses and superficial attitudes are sometimes taught by personnel managers and popular authors. The deeper human qualities of understanding, of sympathy in its larger and original meaning of "feeling with," of tolerance, sincerity—these are the sturdy traits of personality.

Anyone who reads TWENTY DO'S AND DON'T'S FOR DENTISTS in this issue should see a vivid picture of the way we often look to our patients. We are sometimes inattentive, thoughtless, careless. These are the traits that annoy patients. We should discover and correct these irritating faults in ourselves. People do not dislike the dental experience only; they dislike the manner of the human factor performing the service. People can stand pain, but they cannot tolerate a boor. To the patient his condition at the moment in the dental chair is the biggest thing in his life. Our casualness and indifference may cause him more distress than the pain. We would do better if every day each one asked himself, "How do I look to the fellow on the receiving end of the dental bur?"

Edward J. Ryan

OREGON LURES



Top—Claude W. Clifford, D.D.S., of Salem, Oregon, is caught in the act of fly casting. A royal coachman, here used, is his favorite.

Bottom—Here Doctor Clifford is shown bringing a cutthroat trout to net.

This shows H. G. Stoffel, D.D.S., of Portland, Oregon, looking at some of the big ones that didn't get away. Most of these cutthroats were taken with a No. 6 Shelton spinner.

Ask ORAL HYGIENE

Please communicate directly with the Department Editors, V. CLYDE SMEDLEY, D.D.S., and GEORGE R. WARNER, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply. Material of general interest will be published each month.

Lisps With Dentures

Q.—I have an odd case on which I should appreciate your advice.

A patient came in with a six tooth bridge (from cuspid to cuspid, upper). She wanted me to change the cuspid gold crowns into carmichaels and add upper left and right first bicuspids to the bridge. After I made the bridge using her old upper centrals and laterals and cemented the bridge into place, her voice changed. She seemed to lisp all the time. I do not see any reason for this happening as the bridge she has is just the same as the one she has been wearing for the past number of years. What could make her speech different?—E. M., Massachusetts.

A.—The case described is rather puzzling, and the only explanation I can offer is that in replacing the incisors in the new bridge they were not put in the same alinement as they were in the old bridge. Perhaps they do not fit as closely against the gum so that there is a little air escaping above the pontic or possibly they stand out a little more labially. Then there is another possibility in that you had the teeth out a few days and your patient became accustomed to speaking without them and is now having difficulty in adjusting her tongue to the bridge just as she would have in the first place.

In making such a bridge we always plan to use either the Trupontic teeth or baked porcelain saddles on long pin teeth so that the lingual surfaces of the pontic simulate as closely as possible the lingual surfaces of the natural teeth. It may be you'll have to do this in this case to overcome the difficulty with the speech.—GEORGE R. WARNER.

Cementing Teeth

Q.—Is it true that you can cement in a tooth that has been knocked out and, if so, what kind of surgical cement would you use that wouldn't irritate the bone? I have heard of this being done without irritating the alveolus for several years. (This was in case of accidents to children while at play.) Did you ever hear of this or did you ever hear of any such kind of cement?

I have also heard about a cement used to fill up a socket immediately after extraction that will do away with postoperative pain and will be absorbed by the circulatory fluids and not be injurious to the alveolar process.

I should appreciate any information you can give me on this and also any information on any surgical cement that does not irritate the bone. —R. C. J., Nebraska.

A.—So far as I know it is not true that a tooth may be cemented into its socket. It can be

replanted after thoroughly filling the root canal, and if it is securely splinted it will grow back in place and will last anywhere from five years on. In a certain majority of the cases in which teeth are transplanted or replanted there is, after a period, a destruction by osteoclastic action. I believe that statistics show that the average time they will remain in place is seven years. I have seen one that was apparently all right after twenty-five years.

There is nothing quite as good to fill a tooth socket, subsequent to extraction, as a normal blood clot. Some dentists fill the socket immediately with dicalcium phosphate in the belief that the clotting will be better and that the filling in of the bone will be a little more rapid than it would be otherwise be. If the clot fails to form or if it breaks down after it has formed and a dry socket obtains, it is then desirable to use a sedative cement or some similar material to fill the socket. This will overcome the pain, induce granulation, and filling in of the socket. But this will not be taken up by the circulatory fluids and will have to be removed after normal granulation has started. —GEORGE R. WARNER.

Stridor Dentium

Q.—I have a patient who is subject to stridor dentium. He is 22 and has beautiful teeth, in perfect occlusion.

The chief complaint is gritting and gnashing of the teeth during sleep. Upon awakening he sometimes finds himself doing this thing involuntarily. The history proves this to be familial since other members of his family do this same thing.

What information can you give me relevant to this defect? There is marked mechanical abrasion of some teeth and the patient desires corrective treatment.

What is the best treatment? How is a "prophylactor" or splint made for this case? I should appreciate details.

2. What is the cause of failure to get anesthesia in infiltration on an upper molar tooth?

The patient presented with pulpitis of an upper first molar. I could not get anesthesia even after repeated injections. Likewise, a tuberosity injection for block anesthesia failed. I finally had to refer the patient for nitrous oxide.

I never failed in giving local anesthesia in this area before. What is the explanation?—A. J. G., Pennsylvania.

A.—Your letter covers well the causes of stridor dentium. It has been our plan to make a vulcanite splint that would snap over the teeth of the upper jaw, covering all the teeth, and having this splint in good occlusion with the lower teeth perfectly smooth. The patient then can slide the lower teeth around on this splint without injuring the teeth or without making any noise. In some cases patients have been cured of the habit of grinding their teeth at night, and the splint hasn't been necessary any longer.

I notice that Prinz and Greenbaum[1] advise a splint of softer rubber in which the lower teeth fit into the splint and the splint clips over the other teeth. This prevents any lateral movement of the lower jaw. I don't know how this would work, but it doesn't appeal to me as being as

[1]Prinz, Hermann and Greenbaum, S. S.: Diseases of the Mouth and Their Treatment, Philadelphia, Lea and Febiger, 1935.

practical as the other type of splint.

2. Failure of anesthesia in the upper molar region, if you use a second division block, is quite unusual. We find individual variation in anatomy and I suspect that this is a case of variation in the position of the nerve trunk. Infiltration is not always successful in the maxillary molar region. —GEORGE R. WARNER.

Missing Lower Posterior Teeth

Q.—Your aid is solicited in the following case: a patient presented herself for making a new full upper denture; had one she has been wearing for many years, probably twelve. In the lower jaw on both right and left, all teeth posterior to the first bicuspids are missing, all the rest being present. She has not been using any restoration to supply the missing lowers.

As usually happens where the patient wears a full upper with missing lower posteriors, the denture seems to "ride up" over the anterior ridge into the labial fold with the resultant softening of the membranes in that region. This patient has in addition the formation of numerous lumps or pads, glistening red in appearance, just below the labial fold.

In the making of a new full upper denture together with a lower lingual bar, the following questions arise: What should be done about the soft mobile tissue and the pads? What treatment is indicated? Will it help any to have the patient discontinue wearing the present denture for a while? What material should I use for the impression? With the proper restorations might the tissues return to normal and, if so, will a new denture then have to be made?

Why is it that so many patients with teeth missing, as I have described, will fail to use the lower restoration thereby causing themselves eventual injury?—A. S. E., New York.

A.—I would suggest that you cut the labial flange of this upper denture down quite radically. Build it up again with a thick roll of modeling compound that provides a snug contact with the labial aspect of the ridge and flexible overlying tissue, and a smooth rounded surface over which the labial lumps or pads may rest without pressure. Let the patient wear the denture so for a week or two, at which time renew the compound extending the labial flange a little higher if the pads have become less red in appearance and reduced in size. This labial flange of modeling compound may be worn with occasional changes for a number of weeks or until the mouth has been restored to near normal in appearance, after which a new upper denture should be made in conjunction with a partial lingual bar type of construction. The patient should be impressed with the importance of this partial being worn to equalize the occlusal stress and prevent further traumatization of the anterior portion of the upper jaw.

You ask why so many patients fail to use the lower restoration, thus causing themselves injury. I think that when this occurs the dentist is almost invariably to blame in the matter either for making a crude, ill fitting partial denture that a patient should not be expected to wear, or for not instructing him convincingly on the importance of wearing it, or for not making definite follow up appointments with the patient for inspection, adjustments, and further instruction or rebasing,

and alterations, as the need for such may develop. — V. C. SMEDLEY.

Removing Calculus

Q.—I am attempting to secure information concerning the difficulties in the thorough scaling of a mouth in which calculus is extremely adherent to the teeth. My instruments I sharpen before each sitting and, despite this, I must use an excessive amount of force to dislodge these accretions and even then they come off, not in one piece but in many pieces requiring constant repetition of the work. The soft tissues suffer too with all this force being used, especially is this true in the posterior region.

Is it possible to prescribe a mouth wash which will soften these accretions somewhat?

It has been suggested to me to prescribe a solution of sodium chloride for home use to accomplish this. Is this at all effective? If so, how strong would you prescribe it?—M. N. F., New Jersey.

A.—In reply to your letter let me say that many other dentists experience the same trouble you do. We pursue the same course that you outline with the possible exception that we do not attempt to remove all the deposits at one sitting. Thus we avoid much trauma of the soft tissues and reduce the gingival inflammation sufficiently to make the next sitting a little easier from the point of view of being able to see the deposits better. Moreover the deposits are more easily removed at second and third sittings than at the first sitting. That is to say, they are less adherent on successive sittings.

Some years ago Joseph Head[2] of Philadelphia advocated the use of a tartar solvent which I tried. There was some burning of the soft tissues and the teeth were endangered, so its use was discontinued.

Prinz and Greenbaum[3] speak of the use of phloroglucin-sulphuric-acid compound to assist in the disintegration of tartar and say it has given universal satisfaction.

I know of nothing that would be safe for the patient to use at home to soften tartar.—GEORGE R. WARNER.

Areas of Erosion

Q.—I have a patient, a man, 23, who has 20 gingival cavities or areas

[2]Head, Joseph: The Use of Tartar Solvent, D. Cosmos 53:233, 1911.

[3]"To facilitate the disintegration of the hard concretions upon the root surfaces of the teeth, so as to render them more friable to the scaler, various acids and acid salts in solution have been recommended. In 1913, F. Hecker introduced a phloroglucin-sulphuric-acid compound, for the purpose of assisting in the disintegration of tartar, which has given universal satisfaction; it deserves to be recommended.

"The phloroglucin-acid compound is prepared as follows: Place 1 gm. (15 gr.) of phloroglucin (Merck) into a Erlenmeyer flask, add 15 cc. of pure sulphuric acid and warm very slowly with gentle agitation. Within a few minutes a clear solution is obtained. Add this solution with constant agitation to 100 cc. of distilled water and allow it to stand for a few days. Decant the clear solution into a glass-stoppered bottle.

"The technique of applying the phloroglucin-acid solution or any other liquid caustic into a pyorrhetic pocket is very simple. A looped iridoplatinum applicator is dipped into the solution and carefully passed into the deepest portion of the pocket. The slightest contact of the droplet with the soft or hard tissues will disengage it at once from the loop and it will readily flow over the moist surface. The application is repeated several times until the pocket is fairly well filled with the fluid. A piece of cotton is placed over the opening and the acid is allowed to remain for one or two minutes before the scaler is inserted. The acid solution may be applied several times during the scaling process. After the scaling is finished the pocket is thoroughly flushed with warm water to remove the débris.—Prinz, Hermann and Greenbaum, S.S., Diseases of the Mouth and Their Treatment, Philadelphia, Lea & Febiger, Page 129, 1935.

of erosion. These cavities range from minute ones to those that extend in some cases almost to height of contour. Four of the teeth are not affected as yet, but I believe I can detect a slight softening or starting point on two of these four. This patient came to my office for the first time January 14, 1937. He says that he first noticed the cavities or erosion about two months ago, and since then many others have appeared.

There are no signs of these cavities on the lingual surface of any of these teeth.

There are only four small occlusal cavities in his posterior teeth and no proximal cavities in anteriors or posteriors.

There is little calculus or stain in his mouth.

He has never had a restoration placed in any of his teeth up to the present time.

The cavities are not sensitive and the gum tissue is pink and firm. I questioned him as to his diet, and he eats the following every day:

Breakfast: cereal with milk, two soft boiled eggs, toast and coffee (1 cup).

Dinner: mostly meat, few potatoes and bread, generally a salad such as lettuce, slaw or something similar.

He eats no lunch at a regular hour, but all during the day will drink at least one pint of milk, eat several oranges, apples, slices of cold meat, and raw carrots.

He has never missed a day of work as a truck driver on account of illness. His height is 5′ 11″ and weight, 165 lbs. As to his weight, he claims he will in a month's time gain or lose 10 to 15 pounds, yet never feels tired.

I referred him to his own physician for a complete examination.

Possibly you have heard of cases similar to this, and could suggest a possible cause, or where to look for the trouble or deficiency.

Would you place a restoration in these teeth before correcting the cause of this erosion?

If the cause of the erosion cannot be found, would you advise placing restorations in these teeth anyhow; in other words, do you think the erosion could be stopped by a restoration, or would it just continue on starting anew at margins of filling? —S. E. S., Pennsylvania.

A.—It is important to know, in this case, if the condition of which you speak is decay or erosion. If it is erosion it is a concavity but has been formed without any softening or any carious action. In this case the only thing I know of to do is to instruct your patient in vertical toothbrushing or the Charters method of brushing, rather than allow him to do any cross brushing.

If it is a case of cervical caries your idea about diet is entirely right. The dietary presented seems deficient in calcium. This deficiency could be corrected by raising the milk content to a quart a day. He should then have added to his diet some fish oils daily during the winter. Having corrected his diet in this manner and seeing that he keeps his teeth free from bacterial plaques by thorough and intelligent brushing, and that he eats little or no candy, you have done all you can in the way of prophylaxis. The caries should then be taken care of as the extent or depth indicates.—GEORGE R. WARNER.

Fluid in Tissues

Q.—I have a patient wearing an upper denture whose gums are spongy, especially in the lingual area. When I press my finger into the lingual tissue there seems to be a great amount of fluid in the tissue.

Would you advise lancing and draining this fluid?

The upper denture does not fit well, and it seems to hurt the patient in a number of places.

Would you advise the patient to go without a denture until the gums are normal again?

This patient has been wearing this upper denture for about a year.

Any information will be appreciated.—S. A. R., Wisconsin.

A.—I would advise roentgenograms of the upper jaw. I do not know what the presence of fluid under the lingual tissue might mean. If the roentgenogram indicates a cyst, just incising is, of course, not sufficient, but instead the cyst sac should be carefully and completely removed.

If the gums will return to normal when the denture is left out for a time, it would be wise to leave it out. This, of course, should be done before making an impression for a new denture.—V. C. SMEDLEY.

Enlarged Gland

Q.—A patient presented herself with a round lump on her neck just under the lower border of mandible and anterior to angle. It is about the size of a small walnut and seems painless and readily movable. The lower first molar on the same side has a cavity and a restoration but no history of pain or swelling. There is no response from any tooth on that side when an electric tester is used.—P. C. P., Iowa.

A.—The lump you speak of in your letter is almost certainly an enlarged lymphatic gland. From your description I would naturally suspect infection in the molar region of the mandible on that side which is in causal relation to the enlarged gland. Roentgenograms should be made of the teeth in a search for the source of the probable infection.

The enlargement of lymphatic glands about the face and neck is a natural and common sequence of infection of tissues which are adjacent to these glands.—GEORGE R. WARNER.

Fractured Teeth

Q.—How do we tell a recent fracture from an old one—as in an accident case? For example, suppose a person files a claim against a restaurant stating that he bit on a stone while eating and fractured an upper central, I examine him, and I do find a fracture. At times it is difficult to tell whether this happened within a few weeks or months. What means have we of telling approximately when the accident occurred? Is there any scientific method?

How would one go about discussing *recent* and *old* fractures of teeth due to some external injury? Do we depend upon seeing a definite ragged or rough edge in the area of injury to convince us that the accident was recent, or can there be the same appearance in an old fracture or chipping of the enamel or dentine?

I examine teeth for several insurance companies for food hazard claims. Daily, I see teeth, alleged to have been broken in an accident. I have to protect my companies by giving honest opinions. I should like to know more about the scientific angle of this subject.—C. A. L., Massachusetts.

A.—It should be perfectly apparent to anyone if a fracture had occurred yesterday or three months ago. But to decide as between a few days or a few weeks, I don't believe would be possible.

Tooth enamel is so hard, a fracture could go on for quite a little while and still look as though it might have occurred within the last few days. The severity of the fracture, of course, and the absence of pulpitis or pericementi-

tis, would be factors that would influence your opinion as to the time which had elapsed since the accident had occurred. The roentgenograms would also be helpful in determining time, within reasonable limits, but of course not as between days. The strength or frailty of the tooth would also be a factor as between the tooth having been fractured by biting on a cherry seed, or by falling against a cement sidewalk. No doubt all of these things have occurred to you and many others, so I won't attempt to say anything more about it. So far as I know there is nothing in the literature on this subject.—GEORGE R. WARNER.

Myasthenia Gravis

Q.—A patient came to me today saying that when he eats his meals and is eating anything that requires mastication like a steak his jaws completely play out and he has to stop eating. The condition is such that he is eating nothing but softer foods.

He has been to two specialists in Pittsburgh, Pennsylvania. They gave him a list of things that might cause this weakness such as neurosis, intestinal irritation, infected third molars, or impacted molars. He came to me for roentgenograms of the third molars. I found an unerupted lower left third molar. It is in proper alinement, but unerupted. The patient is about 40 years old. He does not complain of any pain. He has had his tonsils and adenoids removed. I could find no infection around these molars.

Do you think this unerupted tooth could cause this? Have you any suggestions to make on the case? What he cannot understand is why it never did this before.—P. B. B., Pennsylvania.

A.—The case described in your letter presents to my mind the picture of myasthenia gravis. There is not a great deal that can be done for this condition. It probably would be wise to suggest to the physicians on the case that it might be myasthenia gravis and have them prove or disprove this diagnosis.

It is questionable if the unerupted third molar is in causal relation to this condition. However, as these unerupted third molars frequently have an area of infection around them, it probably would be wise to have this removed as a possible cause. —GEORGE R. WARNER.